

PATIENT REGISTRATION AND DEMOGRAPHIC INFORMATION

Full Name (first, middle, last) \_\_\_\_\_ Social Security # \_\_\_\_\_

Sex \_\_\_\_\_ Date of Birth \_\_\_\_\_ Current Age \_\_\_\_\_ Maiden Name \_\_\_\_\_

Address \_\_\_\_\_  
Street City State ZIP

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Work \_\_\_\_\_

Email \_\_\_\_\_

Preferred number for phone calls:  Home  Cell  Work Can message be left?  Yes  No

Preferred method for Auto-Reminder Communications:  Home phone  Cell (text)  Cell (voice mail)  Email

Birth Place \_\_\_\_\_ Preferred Language \_\_\_\_\_

Single  Married  Separated  Divorced  Widowed Hispanic?  Hispanic  Non-Hispanic  Decline to Provide

RACE (check all that apply):  American Indian or Alaska Native  Asian  Black or African American  White  
 Native Hawaiian or Other Pacific Islander  Other Race or Mixed Race  Decline to Provide

Referred to IGO by:  Dr. \_\_\_\_\_  Friend/Patient of IGO \_\_\_\_\_  Insurance Company

Person to Notify in Case of Emergency \_\_\_\_\_ Relationship \_\_\_\_\_

Preferred Language \_\_\_\_\_ Notify on Admission to Hospital?  Yes  No

Phone \_\_\_\_\_ Address \_\_\_\_\_

Employment Status  Part Time  Full Time  Self Employed  Retired  Student  Not Employed Occupation \_\_\_\_\_

Employer \_\_\_\_\_ Employer Phone \_\_\_\_\_

Employer Address \_\_\_\_\_  
Street City State ZIP

Full Name of Insurance Subscriber (Guarantor) \_\_\_\_\_

Self  Spouse  Parent  Other \_\_\_\_\_ Subscriber Social Security # \_\_\_\_\_

Subscriber Sex \_\_\_\_\_ Subscriber Date of Birth \_\_\_\_\_ Subscriber Phone \_\_\_\_\_

Insurance Company \_\_\_\_\_ Subscriber # \_\_\_\_\_ Group # \_\_\_\_\_

Full Name of Secondary Insurance Subscriber \_\_\_\_\_

Self  Spouse  Parent  Other \_\_\_\_\_ Subscriber Social Security # \_\_\_\_\_

Insurance Company \_\_\_\_\_ Subscriber # \_\_\_\_\_ Group # \_\_\_\_\_

Subscriber Sex \_\_\_\_\_ Subscriber Date of Birth \_\_\_\_\_ Subscriber Phone \_\_\_\_\_

**It is your responsibility to provide us with all of your medical insurance information including Primary and Secondary insurances (if any) before you are seen at IGO.**

AUTHORIZATION TO PAY PHYSICIAN AND ASSIGNMENT OF BENEFITS:

I hereby assign all medical and/or surgical benefits, to include major benefits to which I am entitled, and authorize payment directly to IGO Medical Group, AMC. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment will remain as valid as the original. I hereby authorize IGO Medical Group to release all information necessary to my insurance companies to secure payment.

I understand that I am financially responsible for all charges incurred whether or not covered by my insurance.

Signature \_\_\_\_\_ Date \_\_\_\_\_